		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0041756

Facility Name: Rosewood Care Center Rockford

Address: 1660 South Mulford Road (Number) Rockford (City) 61108 (Zip Code)

County: Winnebago

Telephone Number: (815) 397-8700 **Fax #** ( )

IDPA ID Number: 041756

Date of Initial License for Current Owners: 05/20/96

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: : Cindy A. Tefteller **Telephone Number:** (618) 465-7717

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/2000 to 06/30/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) Accountant's Compilation Report Attached (Date)
(Print Name and Title) Cindy A. Tefteller
(Firm Name & Address) C.J. Schlosser & Company, L.L.C.
233 East Center Drive, Alton, IL 62002
(Telephone) (618) 465-7717 Fax # (618) 465-7710

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center Rockford # 0041756 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	120	Skilled (SNF)	120	43,800	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,800	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			12,603	12,603	8
9	SNF/PED					9
10	ICF	5,138	11,344		16,482	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,138	11,344	12,603	29,085	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.40%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 05/20/96

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 05/20/96 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 58 and days of care provided 12,603

Medicare Intermediary Tri-Span

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/2001 Fiscal Year: 06/30/2001

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center Rockford # 0041756 **Report Period Beginning:** 07/01/2000 **Ending:** 06/30/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	170,794	15,187	9,833	195,814		195,814		195,814			1
2	Food Purchase		125,982		125,982		125,982	(5,835)	120,147			2
3	Housekeeping	107,096	19,861		126,957		126,957		126,957			3
4	Laundry	35,478	11,513		46,991		46,991		46,991			4
5	Heat and Other Utilities			93,367	93,367		93,367	191	93,558			5
6	Maintenance	22,753	11,298	53,461	87,512		87,512	17,452	104,964			6
7	Other (specify):* Sanitation Services			10,420	10,420		10,420		10,420			7
8	**TOTAL General Services**	336,121	183,841	167,081	687,043		687,043	11,808	698,851			8
	B. Health Care and Programs											
9	Medical Director			15,737	15,737		15,737		15,737			9
10	Nursing and Medical Records	1,605,211	154,929	4,279	1,764,419		1,764,419		1,764,419			10
10a	Therapy	62,327	4,340	603,559	670,226		670,226	175,287	845,513			10a
11	Activities	42,277	1,685	1,952	45,914		45,914		45,914			11
12	Social Services	38,498	66	1,952	40,516		40,516		40,516			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,748,313	161,020	627,479	2,536,812		2,536,812	175,287	2,712,099			16
	C. General Administration											
17	Administrative			425,324	425,324		425,324	(313,797)	111,527			17
18	Directors Fees											18
19	Professional Services			4,920	4,920		4,920	34,172	39,092			19
20	Dues, Fees, Subscriptions & Promotions			26,549	26,549		26,549	(8,937)	17,612			20
21	Clerical & General Office Expenses	134,654	28,613	28,039	191,306		191,306	124,998	316,304			21
22	Employee Benefits & Payroll Taxes			284,857	284,857		284,857	28,564	313,421			22
23	Inservice Training & Education											23
24	Travel and Seminar			893	893		893	(128)	765			24
25	Other Admin. Staff Transportation			8,020	8,020		8,020	19,626	27,646			25
26	Insurance-Prop.Liab.Malpractice			34,742	34,742		34,742	4,297	39,039			26
27	Other (specify):*											27
28	**TOTAL General Administration**	134,654	28,613	813,344	976,611		976,611	(111,205)	865,406			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,219,088	373,474	1,607,904	4,200,466		4,200,466	75,890	4,276,356			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Rosewood Care Center Rockford #0041756 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			1,530	1,530		1,530	227,265	228,795			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			100,316	100,316		100,316	308,130	408,446			32
33	Real Estate Taxes			96,527	96,527		96,527		96,527			33
34	Rent-Facility & Grounds			882,048	882,048		882,048	(870,450)	11,598			34
35	Rent-Equipment & Vehicles			34,931	34,931		34,931		34,931			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,115,352	1,115,352		1,115,352	(335,055)	780,297			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		212,374	19,371	231,745		231,745	(275)	231,470			39
40	Barber and Beauty Shops			13,889	13,889		13,889		13,889			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,700	65,700		65,700		65,700			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		212,374	98,960	311,334		311,334	(275)	311,059			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,219,088	585,848	2,822,216	5,627,152		5,627,152	(259,440)	5,367,712			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center Rockford # 0041756 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(5,592)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,257)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(16,605)	32		10
11	Discounts, Allowances, Rebates & Refunds	(275)	39		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(243)	2		13
14	Non-Care Related Interest	(100,316)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(3,000)	20		17
18	Fines and Penalties				18
19	Entertainment	(128)	24		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,684)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(4,936)	20		28
29	Other-Attach Schedule Marketing Salary	(53,216)	21		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (191,252)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(68,188)	Var	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (68,188)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (259,440)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Rosewood Care Center Rockford

ID# 0041756

Report Period Beginning: 07/01/2000

Ending: 06/30/2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Marketing Salary	$ (53,216)	21	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(53,216)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rosewood Care Center Rockford # 0041756 **Report Period Beginning:** 07/01/2000 **Ending:** 06/30/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(5,835)	0	0	0	0	0	0	0	0	0	0	(5,835)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	191	0	0	0	0	0	0	0	0	191	5
6	Maintenance	0	0	17,452	0	0	0	0	0	0	0	0	17,452	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(5,835)	0	17,643	0	0	0	0	0	0	0	0	11,808	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	175,287	0	0	0	0	0	0	0	0	0	175,287	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	175,287	0	0	0	0	0	0	0	0	0	175,287	16
	C. General Administration													
17	Administrative	0	(425,324)	111,527	0	0	0	0	0	0	0	0	(313,797)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	1,072	33,100	0	0	0	0	0	0	0	0	34,172	19
20	Fees, Subscriptions & Promotions	(9,620)	0	683	0	0	0	0	0	0	0	0	(8,937)	20
21	Clerical & General Office Expenses	(58,473)	200	183,271	0	0	0	0	0	0	0	0	124,998	21
22	Employee Benefits & Payroll Taxes	0	0	28,564	0	0	0	0	0	0	0	0	28,564	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(128)	0	0	0	0	0	0	0	0	0	0	(128)	24
25	Other Admin. Staff Transportation	0	0	19,626	0	0	0	0	0	0	0	0	19,626	25
26	Insurance-Prop.Liab.Malpractice	0	0	4,297	0	0	0	0	0	0	0	0	4,297	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(68,221)	(424,052)	381,068	0	0	0	0	0	0	0	0	(111,205)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(74,056)	(248,765)	398,711	0	0	0	0	0	0	0	0	75,890	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rosewood Care Center Rockford # 0041756 **Report Period Beginning:** 07/01/2000 **Ending:** 06/30/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	204,994	22,271	0	0	0	0	0	0	0	0	227,265	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(116,921)	425,051	0	0	0	0	0	0	0	0	0	308,130	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(882,048)	11,598	0	0	0	0	0	0	0	0	(870,450)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(116,921)	(252,003)	33,869	0	0	0	0	0	0	0	0	(335,055)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	(275)	0	0	0	0	0	0	0	0	0	0	(275)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(275)	0	0	0	0	0	0	0	0	0	0	(275)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(191,252)	(500,768)	432,580	0	0	0	0	0	0	0	0	(259,440)	45

Facility Name & ID Number Rosewood Care Center Rockford # 0041756 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Larry Vander Maten	75.00%	See Attached List		See Attached List		
Darrell Hoefling	25.00%	See Attached List		See Attached List		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Management Fee	$ 425,324	HSM Management Services, Inc.	100.00%	$	$ (425,324)	1
2	V								2
3	V	10a	Therapy	603,559	Rosewood Therapy Services, Inc.	0.00%	778,846	175,287	3
4	V								4
5	V	34	Rent	882,048	Rockford Real Estate LLC	0.00%		(882,048)	5
6	V	30	Depreciation		Rockford Real Estate LLC		204,994	204,994	6
7	V	32	Interest		Rockford Real Estate LLC		421,835	421,835	7
8	V	32	Amortization - Loan Fee		Rockford Real Estate LLC		3,216	3,216	8
9	V	21	Office Expense		Rockford Real Estate LLC		200	200	9
10	V	19	Professional Services		Rockford Real Estate LLC		1,072	1,072	10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,910,931			$ 1,410,163	$ * (500,768)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center Rockford # 0041756 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	See Schedule VIII	$	HSM Management Services, Inc.	100.00%	$ 111,527	$ 111,527	15
16	V	21	See Schedule VIII		HSM Management Services, Inc.	100.00%	183,271	183,271	16
17	V	22	See Schedule VIII		HSM Management Services, Inc.	100.00%	28,564	28,564	17
18	V	25	See Schedule VIII		HSM Management Services, Inc.	100.00%	19,626	19,626	18
19	V	30	See Schedule VIII		HSM Management Services, Inc.	100.00%	22,271	22,271	19
20	V	34	See Schedule VIII		HSM Management Services, Inc.	100.00%	11,598	11,598	20
21	V	19	See Schedule VIII		HSM Management Services, Inc.	100.00%	33,100	33,100	21
22	V	26	See Schedule VIII		HSM Management Services, Inc.	100.00%	4,297	4,297	22
23	V	6	See Schedule VIII		HSM Management Services, Inc.	100.00%	17,452	17,452	23
24	V	5	See Schedule VIII		HSM Management Services, Inc.	100.00%	191	191	24
25	V	20	See Schedule VIII		HSM Management Services, Inc.	100.00%	683	683	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 432,580	$ * 432,580	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center Rockford # 0041756 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Larry Vander Maten	President	Management	75.00%	740,478	3	5.81%	Salary	$ 37,014	17-8	1
2	Darrell Hoefling	Vice-President	Management	25.00%	220,159	3	5.81%	Salary	12,338	17-8	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 49,352		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center Rockford # 0041756 Report Period Beginning: 07/01/2000 Ending: 6/30/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: HSM Management Services, Inc.
Street Address: 11701 Borman Drive, Suite 315
City / State / Zip Code: St. Louis, MO 63146
Phone Number: (314) 994-9070
Fax Number: (314) 994-9912

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Salaries - Officers	Total Cost	75,137,033	17	$ 849,990	$ 849,990	4,362,613	$ 49,352	1
2	21	Salaries - Others	Total Cost	75,137,033	17	2,658,369	2,658,369	4,362,613	154,350	2
3	22	Payroll Taxes	Total Cost	75,137,033	17	282,151		4,362,613	16,382	3
4	22	Employee Benefits	Total Cost	75,137,033	17	140,469		4,362,613	8,156	4
5	25	Travel	Total Cost	75,137,033	17	180,072		4,362,613	10,455	5
6	30	Depreciation	Total Cost	75,137,033	17	351,550		4,362,613	20,412	6
7	34	Building Rent	Total Cost	75,137,033	17	199,753		4,362,613	11,598	7
8	19	Professional Services	Total Cost	75,137,033	17	570,072		4,362,613	33,100	8
9	21	Telephone	Total Cost	75,137,033	17	200,687		4,362,613	11,652	9
10	26	Insurance	Total Cost	75,137,033	17	74,012		4,362,613	4,297	10
11	21	Taxes & Licenses	Total Cost	75,137,033	17	11,527		4,362,613	669	11
12	21	Office Supplies	Total Cost	75,137,033	17	285,895		4,362,613	16,600	12
13	6	Maintenance	Total Cost	75,137,033	17	300,583		4,362,613	17,452	13
14	5	Heat & Other Utilities	Total Cost	75,137,033	17	3,293		4,362,613	191	14
15	20	Dues & Subscriptions	Total Cost	75,137,033	17	11,759		4,362,613	683	15
16	17	Direct - Admin	Direct Cost	1	1	62,175	62,175	1	62,175	16
17	17	Direct - Admin	Direct Cost	16	16	852,719	852,719	0	0	17
18	22	Direct - Payroll Taxes	Direct Cost	1	1	4,026		1	4,026	18
19	22	Direct - Payroll Taxes	Direct Cost	16	16	51,392		0	0	19
20	30	Direct - Depreciation	Direct Cost	1	1	1,859		1	1,859	20
21	30	Direct - Depreciation	Direct Cost	16	16	25,829		0	0	21
22	25	Direct - Travel	Direct Cost	1	1	9,171		1	9,171	22
23	25	Direct - Travel	Direct Cost	16	16	130,031		0	0	23
24										24
25	TOTALS					$ 7,257,384	$ 4,423,253		$ 432,580	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center Rockford # 0041756 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Firstar		X	Construction Financing	Varies	12/21/94	$ 5,523,000	$ 4,511,252		PRM+1/4	$ 433,699	1
2	Less: Related Party Interest Income Offset										(11,864)	2
3	Amortization of Loan Costs										3,216	3
4	Interest Income										(16,605)	4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 5,523,000	$ 4,511,252			$ 408,446	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 5,523,000	$ 4,511,252			$ 408,446	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center Rockford # 0041756 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 109,800	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 104,327	2
3. Under or (over) accrual (line 2 minus line 1).		$ (5,473)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 102,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 96,527	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	100,225	8
	1997	116,241	9
	1998	107,881	10
	1999	107,053	11
	2000	101,600	12

2000 Payment $50,800

1999 Payment $53,527

Accrual = 1/2 of 2000 payment remaining (50,800) + 1/2 of estimated 2001 tax bill (51,200)

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rosewood Care Center Rockford COUNTY Winnebago

FACILITY IDPH LICENSE NUMBER 0041756

CONTACT PERSON REGARDING THIS REPORT Lou Netemeyer

TELEPHONE (314) 994-9070 FAX #: (314) 994-9912

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	12-34-102-022	Rosewood Sub Pt NW1/4 Sec	$ 97,228.86	$ 97,228.86
2.		34-44-2 Lot 1	$	$
3.	12-34-101-028	Rosewood Sub Pt NW1/4 Sec	$ 4,371.48	$ 4,371.48
4.		34-44-2 Lot 2	$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 101,600.34	$ 101,600.34

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Rosewood Care Center Rockford # 0041756 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 41,042 B. General Construction Type: Exterior Stucco Frame Wood Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home	41,042	1994	$ 262,474	1
2					2
3	TOTALS	41,042		$ 262,474	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center Rockford # 0041756 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	120			1996	$ 3,692,092	$	40	$ 92,302	$ 92,302	$ 476,894	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Left Turn Lane Street			1996	50,239		25	2,010	2,010	10,385	9
10	Parking Lot Paving			1996	95,573		25	3,823	3,823	19,752	10
11	Site Excavation			1996	83,290		25	3,332	3,332	17,215	11
12	Storm & Sanitary Sewers, and Site Water Line			1996	154,171		25	6,167	6,167	31,863	12
13	Sprinkler System			1996	24,160		25	966	966	4,991	13
14	Landscaping			1996	55,477		25	2,219	2,219	11,465	14
15	Architect Fees			1996	35,224		25	1,409	1,409	7,280	15
16	Site Work			1996	9,428		25	377	377	1,948	16
17	Contractor Fee			1996	21,047		25	842	842	4,350	17
18	Title Fee			1996	1,068		25	44	44	222	18
19	Builder's Risk			1996	2,159		25	86	86	444	19
20	Legal Fees			1996	1,851		25	74	74	382	20
21	Construction Interest			1996	29,594		25	1,184	1,184	6,117	21
22	Outdoor Signs, Monument Sign and Facility Signage			1996	14,259		10	1,426	1,426	7,368	22
23	Water Heater/Boiler/Hot Water Booster			1996	16,147		10	1,615	1,615	8,344	23
24	Emergency Generator			1996	29,359		10	2,936	2,936	15,169	24
25	Walk-In Cooler			1996	5,094		10	509	509	2,630	25
26	Alarm Annunciator, Fire Alarm System, Door Alarm			1996	29,030		10	2,903	2,903	14,999	26
27	Wallcovering & Painting			1996	67,810		10	6,781	6,781	35,035	27
28	Kitchen Exhaust Hoods			1996	6,883		10	688	688	3,555	28
29	Sinks/Drains			1996	6,712		10	671	671	3,467	29
30	Nurse Call System			1996	28,100		10	2,810	2,810	14,518	30
31	TV Cable & Antenna, Telephone & Paging Wiring			1996	70,140		10	7,014	7,014	36,239	31
32	Carpet			1996	8,915		10	892	892	4,609	32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Rosewood Care Center Rockford # 0041756 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Leasehold Improvements - Management Company:		$	$		$	$	$	37
38	Office Construction/Improvements	1995	444		5			444	38
39	Office Design	1995	41		5			41	39
40	Office Shelving	1996	95		4			95	40
41	Office Expansion	1996	420		4			420	41
42	Office Expansion	1997	1,123		3			1,123	42
43	Office Expansion	1998	634		3	211	211	587	43
44	Office Addition	1999	313		3	104	104	209	44
45	Door Locks	1999	156		3	52	52	82	45
46									46
47									47
48									48
49	Leasehold Improvements - Facility:								49
50	Computer Cabling	2000	2,392	200	7	200		200	50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,543,440	$ 200		$ 143,647	$ 143,447	$ 742,442	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Rosewood Care Center Rockford # 0041756 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 649,883	$	$ 69,542	$ 69,542	5-7 Yrs	$ 336,680	71
72	Current Year Purchases	73,233	1,330	6,640	5,310	5-7 Yrs	6,640	72
73	Fully Depreciated Assets	19,793					19,793	73
74								74
75	TOTALS	$ 742,909	$ 1,330	$ 76,182	$ 74,852		$ 363,113	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	HSM Management	Various	Various	$ 35,099	$	$ 8,966	$ 8,966	5 Yrs	$ 21,026	76
77										77
78										78
79										79
80	TOTALS			$ 35,099	$	$ 8,966	$ 8,966		$ 21,026	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,583,922	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 1,530	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 228,795	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 227,265	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,126,581	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Section Not Applicable	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Section Not Applicable	$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Section Not Applicable

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ ____ Description: ____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center Rockford # 0041756 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? ☐ YES ☐ NO

SCHEDULE NOT APPLICABLE - ONLY HIRE CERTIFIED AIDES

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM ☐
   - IN OTHER FACILITY ☐
   - COMMUNITY COLLEGE ☐
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM ☐
   - IN OTHER FACILITY ☐
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center Rockford # 0041756 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4		5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a-8	hrs	$	40,108	$	292,930	$	40,108	$ 292,930	1
2	Licensed Speech and Language Development Therapist	10a-8	hrs		7,358		87,902		7,358	87,902	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	10a-8	hrs		46,863		398,014	4,340	46,863	402,354	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	39-8	# of prescrpts					191,402		191,402	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Laboratory, X-Ray, Enterals Other (specify): & Specialty Beds	39-8					19,096	20,972		40,068	13
14	TOTAL			$	94,329	$	797,942	$ 216,714	94,329	$ 1,014,656	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Rosewood Care Center Rockford # 0041756 **Report Period Beginning:** 07/01/2000 **Ending:** 06/30/2001

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/2001 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 424,829	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 64,000)	1,255,767		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	13,515		6
7	Other Prepaid Expenses	423		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Def Income Tax Benefit	26,000		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,720,534	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	11,705		15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)	(1,530)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 10,175	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,730,709	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 283,249	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,116,406		29
30	Accrued Salaries Payable	172,261		30
31	Accrued Taxes Payable (excluding real estate taxes)	40,447		31
32	Accrued Real Estate Taxes(Sch.IX-B)	102,000		32
33	Accrued Interest Payable	51,721		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Management Fees	139,385		36
37	Accrued Rent	133,671		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,039,140	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,039,140	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (308,431)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,730,709	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Rosewood Care Center Rockford # 0041756 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (370,463)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (370,463)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	62,032	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 62,032	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (308,431)	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center Rockford # 0041756 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,990,109	1
2	Discounts and Allowances for all Levels	(3,182,425)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,807,684	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,870,650	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,870,650	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	19,271	13
14	Non-Patient Meals	5,592	14
15	Telephone, Television and Radio	5,257	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 30,120	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	16,605	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 16,605	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Lab Discounts	275	28
28a	Miscellaneous Other Income	2,350	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,625	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,727,684	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	687,043	31
32	Health Care	2,536,812	32
33	General Administration	976,611	33
	B. Capital Expense		
34	Ownership	1,115,352	34
	C. Ancillary Expense		
35	Special Cost Centers	245,634	35
36	Provider Participation Fee	65,700	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,627,152	40
41	**Income before Income Taxes (line 30 minus line 40)****	100,532	41
42	**Income Taxes**	(38,500)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 62,032	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Rosewood Care Center Rockford # 0041756 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,109	2,200	$ 58,117	$ 26.42	1
2	Assistant Director of Nursing	1,743	1,817	39,998	22.01	2
3	Registered Nurses	16,262	16,961	345,900	20.39	3
4	Licensed Practical Nurses	23,820	24,843	418,941	16.86	4
5	Nurse Aides & Orderlies	68,288	71,221	689,119	9.68	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,704	3,863	62,327	16.13	8
9	Activity Director					9
10	Activity Assistants	5,015	5,231	42,277	8.08	10
11	Social Service Workers	3,915	4,083	38,498	9.43	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,403	20,237	170,794	8.44	15
16	Dishwashers					16
17	Maintenance Workers	2,060	2,149	22,753	10.59	17
18	Housekeepers	14,315	14,929	107,096	7.17	18
19	Laundry	5,138	5,359	35,478	6.62	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,487	13,023	134,654	10.34	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,356	4,541	53,136	11.70	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	182,615	190,457	$ 2,219,088 *	$ 11.65	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	430	$ 9,833	1-3	35
36	Medical Director	Contract	15,737	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	70	1,952	11-3	44
45	Social Service Consultant	70	1,952	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	570	$ 29,474		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	239	4,056	10-3	51
52	Nurse Aides	25	223	10-3	52
53	TOTAL (lines 50 - 52)	264	$ 4,279		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Rosewood Care Center Rockford # 0041756 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
T. Wagner	Administrator	0.00%	$ 62,175
Total Direct Administrator Cost from HSM Mgmt - Line 17, col 7			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 62,175

B. Administrative - Other

Description	Amount
Management Fee	$ 425,324
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 425,324

C. Professional Services

Vendor/Payee	Type	Amount
C.J. Schlosser & Company	Accountant/Consultant	$ 4,707
	Legal	213
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 4,920

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 70,835
Unemployment Compensation Insurance	
FICA Taxes	169,163
Employee Health Insurance	3,629
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
State Unemployment Tax	28,228
Federal Unemployment Tax	9,018
Employee Uniforms	2,053
Employee Physicals	289
Employee Relations	2,399
Management Company Allocations	28,564
Tuition Reimbursement	(757)
TOTAL (agree to Schedule V, line 22, col.8)	$ 313,421

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
Section Not Applicable		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	8,414
Health Care Worker Background Check	
(Indicate # of checks performed 84)	1,182
Misc. Dues/Subscriptions	7,333
Promotional Advertising	6,620
Management Company Allocations	683
Less: Public Relations Expense	(274)
Non-allowable advertising	(1,410)
Yellow page advertising	(4,936)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 17,612

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	765
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 765

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Rosewood Care Center Rockford # 0041756 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	Schedule Not Applicable		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rosewood Care Center Rockford # 0041756 Report Period Beginning: 07/01/2000 Ending: 06/30/2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Association**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **41,885** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **65,700**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **5,592**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **No facility specific audit**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **No**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.